Remington's Think Tank Leadership Exchange

Best Practices

Business Intelligence for Strategic Development

Presented by:
Lisa Remington
President, Remington's Think Tank Leadership Exchange
and Publisher, The Remington Report

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Meet Lisa Remington

Lisa Remington, President
Remington's Think Tank Leadership Exchange and The Remington Report

Celebrating 30 Years As A Trusted Advisor

Lisa is a growth and strategy advisor with extensive knowledge across the care continuum for three decades. She is well-known for her strategic analysis of payment, policy, and marketplace trends. She understands the challenges and opportunities facing leaders in home care and across the healthcare ecosystem.

As the publisher of The Remington Report, and president of the Think Tank Leadership Exchange, she has earned a trusted industry voice for her ability to navigate through disruption, identify new growth and revenue opportunities, position and expand home care's future, and define collaborative partnerships between hospitals, health systems, ACOs, payers, physicians, and home and community-based organizations.

Lisa has led C-suite education to over 10,000 organizations through a variety of platforms, including think tanks, strategic improvement programs, consulting, board retreats, executive leadership programs, and peer-to-peer networking groups.

Lisa has personally authored thousands of healthcare articles, forecasting reports, special industry market reports, and has maintained a track record of 100% accuracy in predicting emerging healthcare trends and value-based solutions. Her healthcare career began in hospital business operations and as a turn-around specialist in home care.

BEST PRACTICES

Market Intelligence to Improve Discharge Planning and Readmissions

1. **Best Practices: Care Transitions**
2. **Best Practices: Medical Surgical Discharges**
3. **Best Practices: Chronic Care Management**
4. **Best Practices: Patient Engagement Tools**

01

Care Transition Best Practices

Cost of Inadequate Care Transitions

Researchers estimate that in just one year, $25 to $45 billion is spent on avoidable complications and unnecessary hospital readmissions, the result of inadequate care coordination and insufficient management of care transitions.

Discharge Planning Tie Into Care Transitions

- A recent study of patients surveyed at discharge indicated that 41% could not state their diagnosis
- 37% could not state the purpose of their medications, and
- 86% could not identify the side effects of their medications.

Best Practice Care Transitions: Hospital HCAHPS

When You Left the Hospital

15. During this hospital stay, did doctors, nurses, or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
16. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

Understanding Your Care

20. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I left.
21. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
22. When I left the hospital, I clearly understood the purpose of taking each of my medications.

Additional Resource: Lack of Patient Instructions Disrupt Care Transitions

Best Practice: Discharge Planning Team Member

Patient experience measures dropped a bit from 2017-2021, according to CMS's summary of the HCAHPS report

TABLE 3–2 Hospital patient experience measures declined from 2019–2021

H–CAHPS® measure	2017	2018	2019	2020	2021	Percentage point change, 2019–2021
Share of patients rating the hospital a 9 or 10 out of 10	73%	73%	73%	72%	72%	–1
Share of patients who would definitely recommend the hospital	72	72	72	71	70	–2
Share of patients giving top ratings for:						
Communication with nurses	80	81	81	80	80	–1
Communication with doctors	82	81	82	81	80	–2
Responsiveness of hospital staff	70	70	70	67	66	–4
Communication about medicines	66	66	66	63	62	–4
Cleanliness of hospital environment	75	75	76	73	73	–3
Quietness of hospital environment	62	62	62	63	62	0
Understanding their care when they left the hospital (care transitions)	53	53	54	52	52	–2
Share of patients who received discharge information	87	87	87	86	86	–1

Note: H–CAHPS® (Hospital Consumer Assessment of Healthcare Providers and Systems®). H–CAHPS is a standardized 32-item survey of patients' evaluations of hospital care. The survey items are combined to calculate measures of patient experience for each hospital. The H–CAHPS measures included in the table are "top-box," or the most positive, response to H–CAHPS survey items. Each year's results are based on a sample of surveys of hospitals' patients from January to December. Results in 2020 include only surveys from patients discharged July to December 2020 rather than the customary full year.

Source: CMS summary of H–CAHPS public report of survey results tables.

Best Practice: Investigate Referrals Care Transition Results

Patients who reported that YES, they were given information about what to do during their recovery at home.
82%; National average: 86%
Hawaii average: 84%
Patients who "Strongly Agree" they understood their care when they left the hospital.
50%; National average: 51%
Hawaii average: 48%

Kuakini Medical Center
347 North Kuakini Street
Honolulu, HI 96817
808-536-2236
Overall star rating

Patient survey rating

Hospital Care Compare
https://www.medicare.gov/care-compare/?redirect=true&providerType=Hospital

Examples of Care Transition Programs

- Visiting Nurse Services to Fill Gap in Primary Care
- VNA Ohio – The Bridge Program
- Sharp Grossmont Hospital: Care Transitions to Manage SDOH
- Sound Physicians: Proactive Team-Based Care Engagement Improves Care Transitions

How Proactive Team-Based Care Engagement Improves Care Transitions

Care Transitions Intervention Model to Manage Social Determinants of Health

Review Your Care Transition Tools

- **Competitive Tools to Improve Care Transitions with Your Referral Partners and Patients**
- 3 differentiation tools to overcome the challenges of efficient care transitions
- 4 care transition challenges faced by home-based providers
- 7 care transition referral-management capabilities you need to have
- 6 care transition solutions your intake team must have
- 6 ways to create a more satisfying care experience for patients, families, and caregivers
- 5 care transition capabilities to drive better outcomes
- 3 things referral partners want from home-based providers

4 Care Transition Challenges and How to Solve Them

https://remingtonreport.com/intelligence-resources/white-papers/4-care-transition-challenges-and-how-to-solve-them/

Best Practices: Care Transitions & Discharge Planning

- Improved care transitions tie back to the quality of discharge planning and communications
- Improved care transitions tie back to real-time referral communications
- Improved care transitions tie back to real-time communications with family and caregivers
- Improved care transitions tie back to readmissions
- Improved care transitions tie back to patient satisfaction scores

My Take:

Care transitions is a holistic, seamless, integrated model that cannot be siloed

Hospital readmissions cost Medicare $26 billion annually

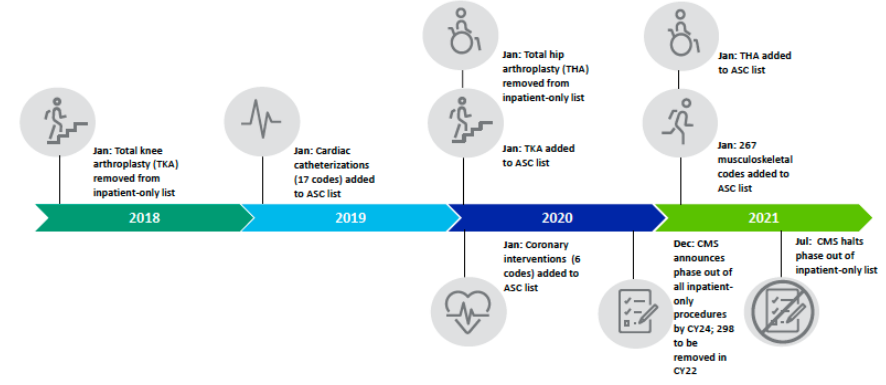
More than 3.8 million adult hospital patients are readmitted every year, with an average readmission cost of $15,200

02

Best Practice: Medical Surgical Discharges

Site of Care Change

CMS has removed procedures from the inpatient-only list and added them to the ASC coverage list



Sources: CMS, Moody's Investors Service

Episode-Based Models

- Payment for entire episode of care (30-60-90 days)
- Single medical condition or surgical condition
  - Hip or knee replacement
  - Cardiac
  - Stroke
- Care at home participation:
  - Requires an advance care plan and coordination with acute, post-acute, and ambulatory partners
  - Care coordination: care managers, therapists, and community workers

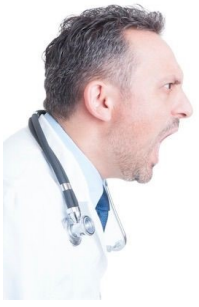
Bundled payments have resulted in a 20.8% decrease in total spending per episode

Bundled payment relies on a certain level of risk. If providers can decrease the cost of the services below the bundled payment price, they can pocket the savings.

However, if the costs are higher, providers bear a financial loss.

Bundled payment arrangements present many opportunities to re-tool the types and mix of post-acute care, and materially improve patient care and lower costs

Ambulatory Care Physicians: Frustrations



Working Through Physician Partnership Issues

1. No established relationships
2. Do not know where their patient is
3. Delayed communications
4. Lack of information

Best Practice: Improve Surgical Care Transitions

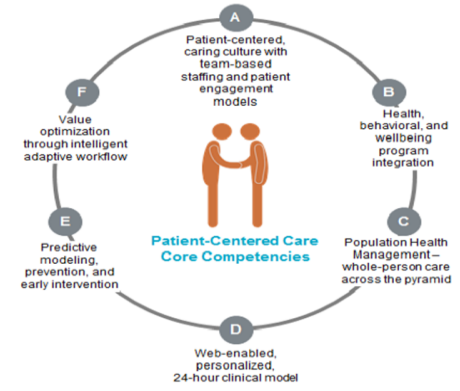
- Wound care education
- Supplies
- Pain control
- Approvals for non-home post discharge locations
- Follow-up plans for wounds, ostomies, and drains at discharge
- Challenges to surgical discharges:
    - Home environment
    - Caregiver availability
    - Team communication issues
    - Post discharge care coordination

Source: Mapping the Discharge Process After Surgery: JAMA Surgery

03

Best Practice: Chronic Care Management

Physicians: Core of Care Transformation



Source: MMC Advantage

Physicians Managing Chronic Care

- Manage chronic care and complex illnesses
- Medically focused populations
- Goal: Shared savings: lowering utilization medical expenses

Physician population focus:

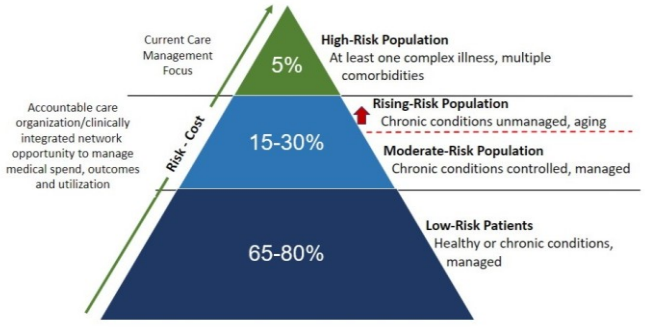
* Cancer
* Diabetes
* Dialysis
* Asthma
* Heart disease
*Opioid addiction
* Alzheimer's
* Depression

More than 2/3 of the chronic care population have at least one chronic condition

Care at home participation: Model requires care coordination across broader set of services

Best Practice: Managing Higher Risk Patients

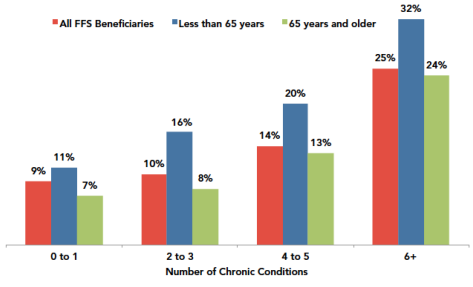
Expand the focus to "rising risk" patients. The sickest 5 percent of the patient population representing the majority of costs and the best opportunity to realize significant savings.



As insurers move toward true risk-based contracts that include both upside and downside risk, healthcare organizations should broaden their focus to "rising risk" patients. This population can be defined as the 15 to 30 percent of the population with one or more chronic diseases. These patients typically are older, and their illnesses often are unmanaged. Optimizing care and outcomes for these patients is the key to achieving true cost control within a broad-based population.

Best Practice: Readmission Management

Percent of Hospital Readmissions Within 30 Days of Discharge by Number of Chronic Conditions and Age



Total Annual Medicare Spending for Medicare Fee-For-Service Beneficiaries by Number of Chronic Conditions

Medicare Spending: Fee-For-Service Beneficiaries by Number of Chronic Conditions, 2014			
Number of Chronic Conditions	Total Medicare Spending	Percent of Beneficiaries	Percent of Total Medicare Spending
0 to 1 condition	$21,669,516,527	35%	7%
2 to 3 conditions	$58,273,430,854	30%	18%
4 to 5 conditions	$82,724,744,278	21%	26%
6+ conditions	$161,282,073,665	15%	50%
Total	$323,949,765,324		

Metrics That Matter: Chronic Care

HOSPITALIZATION RATE

517/1,000 PER YR
HCC 2.0

DAYS SPENT AT HOME

360 Days Per Year
MANAGED DAYS SPENT AT HOME PER YEAR

TOTAL COST OF CARE

$15,121 PER YR
HCC 2.0

READMISSION RATE

9%
HCC 2.0

MEDICATION MANAGEMENT

99.999% DISPENSING ACCURACY
99.7% COST-EFFECTIVE SUBSTITUTION RATE

SOCIAL DETERMINANTS OF HEALTH

SDOH NEED AND RESOURCE MATCHING IN MULTIPLE BUSINESS SEGMENTS

Data from BrightSpring Health Services / Pharmerica.

04

Best Practices: Patient Engagement Tools

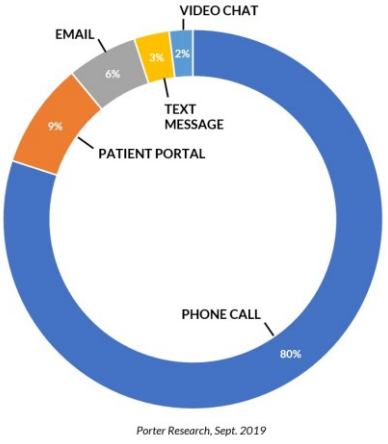
Best Practice: Family Caregiver Communications

- What do family caregivers identify as important areas for choosing a hospice and care-at-home provider?
- What area did family caregivers identify for improvement?
- How is organization's surveys being affected?

Provider Communications With Families

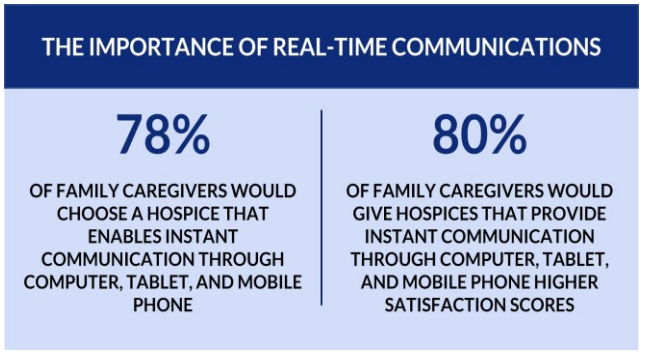
100 hospice leaders responded to a Porter Research study about the ability to communicate with family caregivers.

- 80% report that they still use the telephone as their primary means of communicating with patients (outside of face-to-face visits).



Porter Research, Sept. 2019

What Hospice Consumers Says Impacts Patient Satisfaction



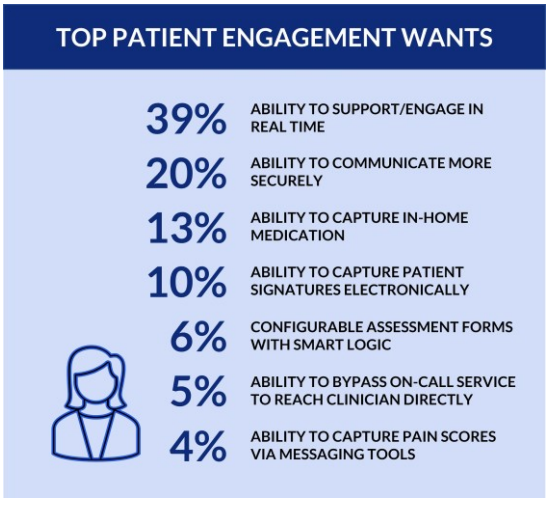
The dominant three communications methods: phone, texting and email came up short in their ability to enable hospice clinical teams to immediately respond to urgent family caregiver needs

Average, only 43% of family caregivers claimed to be “very satisfied” with their hospice providers. Today’s healthcare consumers are tech savvy and they expect real-time, two-way communication. When providers meet this expectation, the results are higher CAHPS scores and more referrals.

Study by CitusHealth

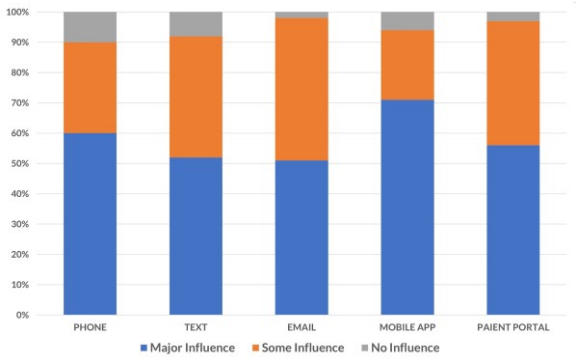
Best Practice: Engagement Tools

7 Preferences Patients Say Can Improve Communications



Communication Gaps: Patient Satisfaction Scores

How Does the Gap Between What Family Caregivers Want and How Today's Hospice and Home-Based Care Providers Communicate Impact Patient Satisfaction?



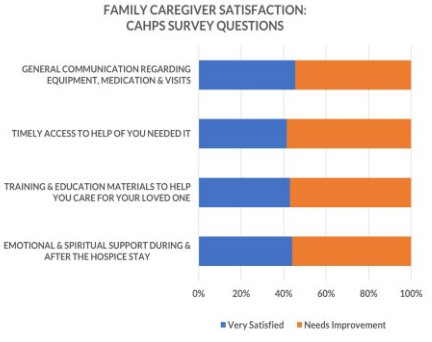
Communication Gaps: Patient Satisfaction Scores

How Does Poor Communication Issues Impact CAHPS Surveys?

On average, only 43% of family caregivers claimed to be "very satisfied" with their hospice providers on the four CAHPS survey questions most impacted by communication:

1. Communication with family,
2. Training family to care for patient,
3. Getting timely help, and
4. Emotional and spiritual support, with only a slight variance in response for each question.

- 57% indicated that providers have room for improvement (responses that included "somewhat satisfied" to "very unsatisfied"). The biggest need for improvement is delivering timely access to help, which should be a red flag for hospice providers that want to avoid unnecessary ER visits and hospitalizations.



Best Practice: Real Time Communication Tools

Aligning Technology Investments With Patient Needs

The Porter Research report identified investment priorities for patient and caregiver communications

Internal Discussions: Communication Technology

Rank 1-5 (5 is the highest)

1. Does your organization have a technology communication investment plan?

2. Does your organization leverage technology to improve communications with family caregivers?

3. Is your current technology increasing staff resources and communications?

Discussion
Identify a list for technology that can improve family caregiver and internal staff communications

Best Practice: Patient Engagement Tools

Disengagement and non-compliance are the top causes of preventable readmissions

Disengagement refers to a patient's disinterest or unwillingness to participate in their care, and non-compliance means they are not following their treatment plan

Tool: Patient Activation Measures

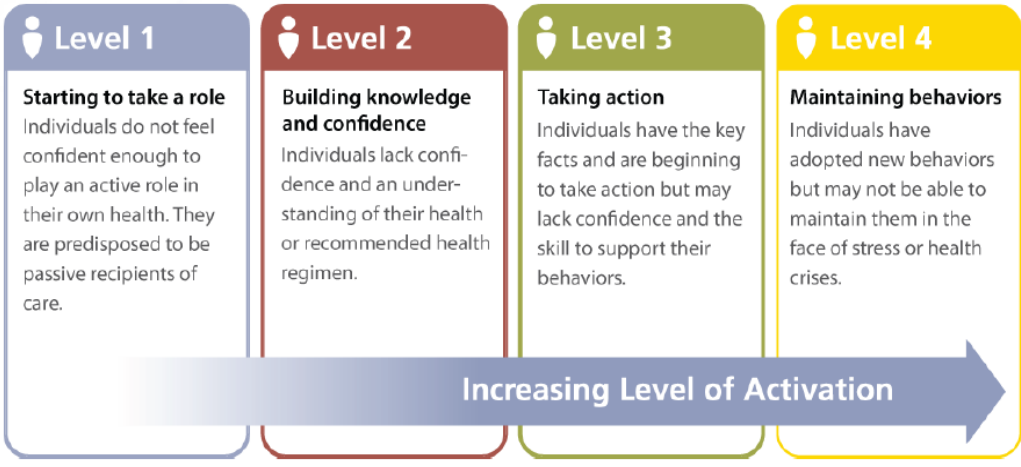
- Patient Activation Measure (PAM)
- Links activation levels to health outcomes, costs, and patients' experiences of care.
- A series of answers to questions—that gauges a person's self-concept as a manager of his or her health and health care. The measure is scored on a 0–100 scale, and people are categorized into four levels of activation, with level 1 the least activated and level 4 the most activated.
- Predicts future ER visits, hospital admissions and readmissions, medication adherence.

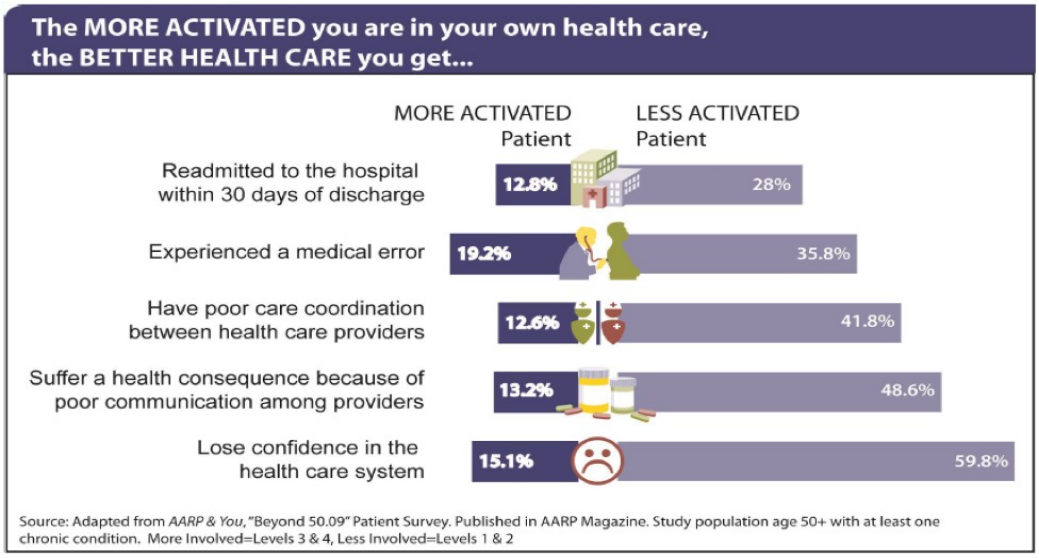
Insignia Health - Activate Your Population

The Patient Activation Measure

- Measures the patient's knowledge, skills and confidence essential to self management
- Stratifies patients into one of four activation levels
- Predicts healthcare outcomes including medication adherence, ER utilization and hospitalization
- Creates a universal language across care settings

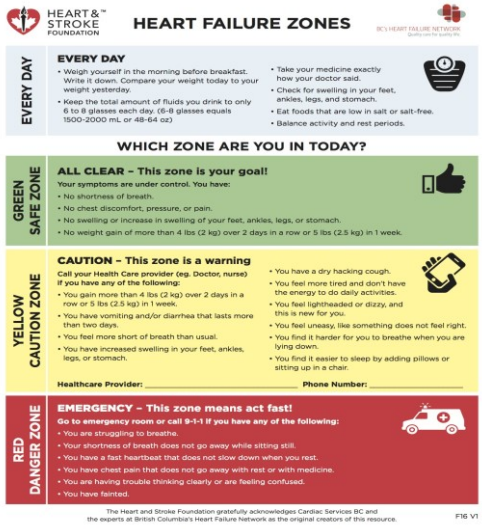
Levels of Activation





Discussion Questions

- **Screening Tools:** How is your organization monitoring patient compliance and engagement?
- What patient engagement tools help to decrease readmissions?
- How is your organization communicating in real-time patient's social determinants of health?



Best Practice: Higher Engagement Opportunities

- **Care coordination and care transitions**. Collaborative and seamlessly connecting all providers along the care continuum.
- **Aligned Incentives.** Quality, financial, outcome improvement initiatives.
- **Clinical Protocols.** Consistent patient transfer, clinical protocols, and processes.
- **Data Integration and Data sharing**. Focus on analytics and more targeted interventions.
- **Real-time Communications**. Patient status
- **Population Health.** Managing chronic care, higher acuity patients
- **Correct Levels of Care.** Immediate and consistent access to high-quality home-based services, placing patients in the optimal levels of care, regardless of payer type
- **Readmissions and ED.** Reductions in readmissions and emergency department visits.
- **Discharge Planning.** Increased hospital throughput, a reduced average length of stay and a more efficient discharge process.

Remington Think Tank Leadership Exchange Upcoming Master Classes

May 16, 2024
Building Relationships with Hospitals and Health Systems
How Home Health, Hospice, Palliative Care, Private Duty, and In-Home Care Providers Can Craft Persuasive Value Propositions and Solve Critical Pain Points Through Home Care Solutions and Resources

June 6, 2024
Establishing Referral Partnerships Through Readmission Management
Opportunities for Home Health, Hospice, Palliative Care, Private Duty, and In-Home Care Providers to Decrease Readmissions, Collaborate, and Deliver Improved Outcomes

June 27, 2024
Building Referral Partnerships with Payers and Medicare Advantage Plans
Opportunities for Home Health, Hospice, Palliative Care, Private Duty, and In-Home Care Providers to Implement Effective Strategies and Foster Relationships

Get the overview of all MasterClass Programs

Live Recording Available
Building Referral Partnerships with ACOs

How Home Health, Hospice, Palliative Care, Private Duty and In-Home Care Can Create Team-Based Care
Received 5-Star Rating

★ ★ ★ ★ ★

Live Recording Available
Building Referral Partnerships with Physicians and Specialists

How Home Health, Hospice, Palliative Care, Private Duty and In-Home Care Can Create Team-Based Care Can Improve Outcomes
Received 5-Star Rating

Additional Think Tank Resources

- Remington Report magazine
[The Remington Report » Remington Report]

- Remingtonreport.com: E-newsletter and Special Reports
https://remingtonreport.com/intelligence-resources/futurefocus/

- Email questions:
remington@remingtonreport.com